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In The
Supreme Court of the United States
October Term, 1986

Otis R. Bowen, Secretary of Health and Human Services,
Petitioner,

v.

Kenneth Kizer, Director of the California Department of Health Services, et al.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether, when Congress has specifically permitted states to employ a separate and higher Medicaid income standard for adult couples than that used for a family of a parent and child during a temporary moratorium period, the Secretary may refuse to approve California's Medicaid state plan amendment establishing such a standard?

2. Whether California could properly rely upon an interpretative guideline promulgated by HHS' Health Care Financing Administration in setting its Medicaid income standard for adult couples, when HHS' regulations contemplate that states may rely upon such guidelines, and when the guideline is consistent with the language of Title XIX of the Social Security Act, and is reasonably related to the purposes of the Act?

PARTIES TO THE PROCEEDING

The Director of the California Department of Health Services is now Kenneth Kizer, M.D. The remaining parties are set forth in the Petition.

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STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of § 1902(a) of the Social Security Act ("the Act"), 42 U.S.C. § 1396a(a), of § 1903(f) of the Act, 42 U.S.C. § 1396b(f), of 42 C.F.R. § 435.1007, and of California Welfare and Institutions Code § 14005.12 are set out in the Appendix to the Petition. (Pet. App. 46a-49a). The Petition omits relevant portions of § 2373(c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1112 ("DEFRA"). That section of DEFRA, in its entirety, together with 45 C.F.R. § 201.3(d), and HHS' Regional Office Manual § 2572-D, are set out at App. 1-2, 7-10, *infra*.

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STATEMENT OF THE CASE

The statement of the case in the Secretary's Petition is incomplete in several respects. First, the Petition does not describe the events leading up to the enactment of California Welfare & Institutions Code § 14005.12(c). Second, the Petition does not discuss HHS' initial reliance upon the "single standard" requirement adopted in the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") as the basis for its disapproval of California's state plan amendment. Third, the Petition does not describe Congress' hostile reaction to HHS' position, which culminated in passage of § 2373(c) of DEFRA ("the moratorium provision"). Finally, the Petition simply omits any mention of the DEFRA Conference Committee's report on that provision, (App. 3-6), which makes clear that, until Congress has had "an opportunity to study and legislate on the mat-

ter," (App. 5), states are expressly permitted to establish adult couple MNILs, as California has done here. Respondents therefore supplement Petitioner's statement of facts.

A. California's Adoption of the Adult Couple MNIL

As set forth in the Petition, Title XIX of the Social Security Act, which established the Medicaid program, requires participating states to provide benefits to the "categorically needy," and permits them the option of providing benefits to the "medically needy." (Pet. at 2-3). California has elected to include the medically needy in its Medicaid program (known as "Medi-Cal").

States must establish income limits to be used in determining Medicaid eligibility for the medically needy. These standards, known as "medically needy income levels" or "MNILs", set the amount of income allotted to an individual or family for non-medical necessities such as food, clothing, and shelter, according to family size. *See* California Welfare and Institutions Code § 14005.12. The remainder of the family's income is its "share of cost". Each month, medically needy individuals or families must incur medical expenses in an amount equal to their share of cost before Medicaid will pay the remaining medical bills incurred during the month. Welfare and Institutions Code §§ 14005.9, 14054.

Until June, 1982, California had a special income deduction which permitted medically needy aged, blind, and disabled people to keep as much income as SSI recipients to meet their non-medical needs. The Legislature repealed this deduction as part of an extensive Medi-Cal reform

package. AB 799, 1982 Stats. Ch. 328, § 8. As a result, the MNIL for two persons was set at $544. In contrast, categorically needy aged, blind, and disabled couples on SSI were, at the time, receiving $838 per month to meet their non-medical needs. (A.R. 336).[1] For the first time, as a condition of receiving Medi-Cal, medically needy pensioners and blind and disabled people were required to live on amounts far below that allotted to SSI recipients.

During the early part of 1983, the California Legislature's Assembly Committee on Aging and Long Term Care held public hearings on the effect of the AB 799 changes in the Medi-Cal program. The testimony at those hearings centered, in large part, on the impact of the sharp increase in the share of cost. Aged and disabled recipients and their advocates testified that sick people were unable to afford both their non-medical expenses and their expenses for outpatient care, such as doctor's visits and prescription drugs. Testimony indicated that the increase in the share of cost was exacerbating widespread malnutrition among the elderly, and, in some cases, was causing unnecessary institutionalization. (A.R. 337-338, 611-822).

As a result of the public outcry concerning the impact of the new income standards, (A.R. 338-39), the Legislature adopted a new formula to determine the MNIL for adult couples, to ensure "that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs." Welfare & Inst. Code

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[1] The reference is to the Administrative Record, filed in the court below.

§ 14005.12(a),(c), as amended by 1983 Stats. Ch. 323, § 124.6. (Pet. App. 49a). The new adult couple MNIL of $709 per month (A.R. 41), was based upon Section 2572-D of the Regional Office Manual ("ROM") published by HHS' Health Care Financing Administration ("HCFA") (App. 7-10). ROM 2572-D provided that states may establish adult couple MNILs, set as high as 133⅓% of the AFDC grant for a family of three, "in order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child." (App. 9).

B. HHS' Disapproval of ROM 2572-D and Congress' Reaction

While California's legislation was still pending, HHS' Regional Office in San Francisco, aware that the State was relying upon ROM 2572-D, requested guidance from HCFA's Bureau of Eligibility, Reimbursement and Coverage ("BERC") concerning the validity of the ROM provision.[2] (A.R. 127, App. 11-12). The Regional Office suggested that the ROM provision was no longer valid in light of § 1902(a)(10)(C) of the Act, 42 U.S.C. § 1396a(a)(10)(C)(i)(III), as amended by § 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248 ("TEFRA"). That provision, (Pet. App. 47a), requires state plans to describe "the single standard to be employed in

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[2] The BERC "reviews existing policy and develops new policy" concerning eligibility for the Medicaid program. CCH Medicare & Medicaid Guide, 1985 Transfer Binder ¶ 34450 at 9236. The Regional Office was required to seek BERC's guidance by 45 C.F.R. § 201.3(b) ("State plan material on which the regional staff has questions concerning the application of Federal policy is referred with recommendations as required to the central office for technical assistance.")

determining income and resource eligibility for all such [medically needy] groups."

In April 1983, in a document entitled "Policy Information For All Regions", the Director of the BERC advised the Regional Administrator: "Establishing different medically needy levels that would vary by family composition, would in effect, result in application of more than a single standard for a group", and would thereby violate TEFRA. (A.R. 131, App. 13-14). The Regional Office, in turn, advised the California Department of Health Services of HCFA's interpretation. (A.R. 139, App. 15-16).

Despite HCFA's position, the California Legislature adopted the adult couple MNIL, and the Department of Health Services subsequently submitted its state plan amendment to HHS. In the meantime, Congress had been alerted to HCFA's new policy regarding the validity of ROM 2572-D. In October, 1983, the House Energy and Commerce Committee reported a bill to the House of Representatives which permitted states to adopt an adult couple MNIL as California proposed. H.R. 4136, 98th Cong., 1st Sess. § 211.

The Committee both approved the substance of ROM 2572-D, and disagreed with HHS' position that TEFRA required its reversal:

> The Committee is at a loss to understand why the Department has decided to alter its policy. . . . The policy is sound. . . . The Committee bill makes clear that [TEFRA's] single standard requirement does not justify a rejection of the valid 1979 policy with respect to two medically needy adults.

H.R. Rep. 98-442, Pt. 1, 98th Cong., 1st Sess. 51 (1983) (App. 18, 19). Recognizing that the literal language of TEFRA would preclude states from maintaining a different income standard for medically needy families of two adults than is applicable to a family of a parent and child, the Committee stated its intent to create a limited exception to TEFRA: "In short, the Committee amendment would relax the single standard requirement only in the limited circumstance" in which a state adopts an adult couple MNIL. *Id.* at 52 (App. 20). The House passed the Committee's provision in H.R. 5394, 98th Cong., 2d Sess. § 361 (1984) (App. 17).

C. The DEFRA Moratorium

When H.R. 5394 went to conference with the Senate, the Conference Committee declined to enact the exception to TEFRA's single standard requirement contained in the House bill, because it was too limited. The Committee was concerned that HHS' "overly literal" reading of TEFRA had created "grave administrative problems for the States" and had "threaten[ed] to cause great hardship for applicants and beneficiaries" in a number of respects, including but not limited to adult couple MNILs. H.R. Rep. 98-861, 98th Cong., 2d Sess. 1367-68 (1984) (App. 4-5). Therefore, the Committee determined to enact a broader but time-limited moratorium, during which the states would be permitted to adopt a variety of "less restrictive" standards and methodologies for their medically needy programs than those required by a strict reading of TEFRA. Accordingly, in § 2373(c)(1) of the Deficit Reduction Act of 1984, ("DEFRA"), P.L. 98-369, 98 Stat. 1112, Congress forbade the Secretary from taking "any compliance, dis-

allowance, penalty, or other regulatory action" against a state during a moratorium period of approximately 30 months because the state uses a standard or methodology which the Secretary considers to violate TEFRA's "single standard" or "same methodology" requirement. (App. 1).

Although the Conference Committee rejected the House provision, it approved the use of adult couple MNILs. Indeed, as the committee report reflects, one of Congress' purposes in enacting § 2373(c) was to prohibit the Secretary from taking any regulatory action against a state based on its use of an adult couple MNIL during the moratorium:

> Section 137[(b)](8) of the Tax Equity and Fiscal Responsibility Act, P.L. 97-248 (TEFRA), amended the Medicaid statute to clarify that [in the Omnibus Budget Reconciliation Act of 1981 ("OBRA"), P.L. 97-35], Congress did not intend to change the policies governing the income and resource standards and methodologies for determining eligibility of the medically needy from those in effect before OBRA. This amendment provided in part that the methodology to be used in determining income and resource eligibility for the medically needy must be the "same methodology" used under the relevant cash assistance program.
>
> . . . [I]t is the understanding of the conferees that the Department has implemented this provision in an overly literal fashion, without taking into account the intent of the TEFRA clarification.
>
> *For example, . . . the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differ-*

> *ences in medically needy income levels among groups of the same family size depending on relative numbers of adults and children.*
>
> The Department's overly restrictive interpretation of section 137[(b)](8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries. . . . The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the matter. (App. 4-5).

Thus, in DEFRA, Congress expressly permitted the states to establish separate medically needy MNILs for adult couples, at least "until the Congress has an opportunity to study and legislate on the matter." (App. 5).

D. The Secretary's Change of Pcsition and The Ninth Circuit's Reaction

In January, 1985, six months after enactment of DEFRA, HCFA's Administrator issued a decision disapproving California s adult couple MNIL. (Pet. App. 38a). The decision avoided reliance upon TEFRA, but rather rested upon § 1903(f) of the Act. 42 U.S.C. § 1396b(f), and the regulation implementing that provision, 42 C.F.R. § 435.1007. (Pet. App. 46a, 48a). Nevertheless, the agency's underlying position was the same as that which had been before Congress: "Regardless of the possible greater maintenance needs of a two-adult family as opposed to an AFDC family of two (one child, one adult), the statute provides for a single MNIL for a family of two." (Pet. App. 42a).

The Ninth Circuit unanimously rejected HHS' attempt to dress the same emperor in new clothes: "[T]he Cali-

fornia plan amendment raises exactly the kind of problem which Congress addressed by establishing a moratorium on HHS implementation of the TEFRA 'single standard' provision." (Pet. App. 17a). Citing the Conference Committee report, the court concluded: "Congress intended the DEFRA moratorium to apply in precisely this situation." (*Id.*)

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REASONS FOR DENYING THE WRIT

I. BECAUSE THE COURT OF APPEALS' DECISION RESTS UPON A STATUTE WHICH IMPOSES A TEMPORARY MORATORIUM, THIS CASE PRESENTS NO IMPORTANT QUESTION OF LAW WHICH NEED BE DECIDED BY THIS COURT

The Secretary's Petition focuses almost exclusively upon the Court of Appeals' holding that ROM 2572-D has legislative effect. However, the court did not rest its judgment only upon that ground, but also relied upon DEFRA's moratorium provision as "an additional, independent reason for reversal." (Pet. App. 16a). Thus, the issue primarily discussed in the Petition is not squarely presented to this Court, since the case can be resolved on the basis of the DEFRA issue. Moreover, the Court of Appeals' DEFRA ruling does not present questions worthy of this Court's review for two reasons: First, because the DEFRA moratorium is, by its terms, temporary; and second, because the Court of Appeals' application of DEFRA is correct on the merits.

A. Congress Enacted the DEFRA Moratorium as a Temporary Measure, and Has Expressed Its Intent to Revisit the Issue of Adult Couple MNILs

When Congress rejected the Secretary's "overly literal" reading of TEFRA in § 2373(c) of DEFRA, it did not intend to close the subject. Rather, Congress sought a temporary solution to the "grave administrative problems for the States" and the threatened "great hardship for applicants and beneficiaries" which had resulted from HHS' "overly restrictive interpretation". (App. 4-5). It therefore enacted a moratorium on the Secretary's enforcement of TEFRA's "single standard" and "same methodology" requirements. § 2373(c)(1) (App. 1). During the moratorium, states are free to establish adult couple MNILs and other "less restrictive" standards and methodologies than those required under a strict reading of TEFRA, limited only by Congress' expectation that they "will be reasonable." (App. 6).

Congress' purpose in enacting the moratorium was to provide itself with "an opportunity to study and legislate on the matter," so that it could fashion a permanent solution to the "unintended, and in some cases, undesirable consequences" of the Secretary's TEFRA enforcement policy. (App. 5). To that end, Congress directed the Secretary to furnish it with a report by July 18, 1985 (twelve months after enactment of DEFRA), "with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs [to the medically needy], and any recommendations for changes in such requirements." § 2373(c)(3) (App. 1). Anticipating that

the Secretary's report would serve as a catalyst for future legislation, Congress also gave itself an additional period to act before the Secretary could again begin his enforcement of TEFRA. Thus, the moratorium established under § 2373(c)(1) ends 18 months after the Secretary submits his report. § 2373(c)(2) (App. 1).

Despite the concerns voiced in the Secretary's Petition as to the consequences of the Court of Appeals' DEFRA ruling, he has not yet submitted the report which Congress mandated. His report is now a full eighteen months overdue. Had he submitted a timely report, Congress might well have already resolved the issues presented in the Petition.

Rather than becoming involved in interpreting § 2373(c) of DEFRA at this juncture, the Court should defer to Congress, which has stated its intent further to address the issue of adult couple MNILs, and indeed, an entire range of issues arising from TEFRA's "single standard" and "same methodology" rules. The Secretary has Congress' ear, but has not spoken. His remedy, if one is due, lies there, rather than with this Court.

B. The Court of Appeals' DEFRA Holding is Correct

The Secretary argues that the court's DEFRA holding is "contrary to clearly expressed congressional intent." (Pet. at 19). However, he does not discuss—or, indeed, even mention—the Conference Committee report, where Congress clearly indicated that § 2373 was intended, *inter alia,* to permit states to maintain adult couple MNILs during the moratorium period. (See pp. 7-8,

supra.) Resting its judgment squarely on the committee report, the Court of Appeals ruled that "Congress intended the DEFRA moratorium to apply in precisely this situation." (Pet. App. 17a-18a). The court followed Congress' intent to the letter.[3]

Rather than focusing upon the report of the Conference Committee and Congress' evident purpose in enacting § 2373(c), the Secretary attempts to show that the DEFRA moratorium is inapplicable here. His hypertechnical arguments, however, are inconsistent with Congress' expressed intent, and are without merit.

First, although he never raised the argument below, the Secretary contends here that TEFRA's requirement that states use a "single standard" and its requirement that states apply the "same methodology" as that used in the related cash assistance program, both of which were the subject of the DEFRA moratorium, are the same. The Secretary claims that the TEFRA amendment was concerned solely "with determining what resources are to be regarded as income for purposes of Medicaid eligibility." (Pet. at 18). He implies that, because California's plan amendment did no more than set the income standard for medically needy adult couples, it is outside the scope both of TEFRA and of the DEFRA moratorium.

This argument ignores the language of TEFRA itself. Section 1902(a)(10)(C), as amended (Pet. App. 47a),

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[3] The moratorium provision originated in the Conference Committee. Thus, the Committee's report is certainly dispositive of Congress' intent—indeed, it is the only legislative history available.

does address the methodology which states must use in determining how much income is available to a Medicaid recipient—the question which was the subject of this Court's opinion in *Atkins v. Rivera*, 477 U.S. —, 91 L.Ed.2d 131, 106 S.Ct. 2456 (1986). But, in addition, the statute separately requires states to use a "*single standard*" for all medically needy groups. It is simply not the case, as the dissent to denial of an en banc hearing below contended, that these terms are "synonomous." (Pet. App. 32a, n.3). *See Camacho v. Perales*, 786 F.2d 32, 43-44 (2d Cir. 1986) (discussing the difference between the two terms);[4] *Morris v. Morrow*, 783 F.2d 454, 461-62 (4th Cir. 1986) (holding that the rule at issue there was a methodology, not a standard). Indeed, the Secretary himself recognized in the preamble to 1981 regulation changes that medically needy income levels are "standards", while rules regarding treatment of income and resources are "methodologies." *Id.* at 462.

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[4] There is no merit to the Secretary's suggestion that the Court of Appeals' interpretation of DEFRA is at odds with that of the Second Circuit in *Camacho, supra*. There, in a case brought by Medicaid recipients to invalidate a *more* restrictive methodology than that used in the SSI program, the State argued that its methodology was in some but not all respects, less restrictive, and therefore was permitted under DEFRA. *Id.* at 42. The Secretary was not a party. The court refused to apply the DEFRA moratorium, both because it had been enacted after the District Court's decision, and because the provision "is too sketchy in detailing Congress's present thinking to be invoked to govern the rights of the parties here." *Id.* The parties in this case, however, are precisely those to whom Congress addressed the moratorium: The Secretary on the one hand, and the State on the other. Moreover, the history of the moratorium provision leaves no doubt but that states have authority to adopt adult couple MNILs, as California proposed here. The moratorium provision governs.

This case plainly concerns "the State's decision as to what income level will be linked with a particular household size", i.e., "the setting of a standard" as Congress used the word in TEFRA. *Camacho, supra,* 786 F.2d at 44. Although TEFRA literally requires a "single standard," DEFRA nevertheless specifically permits states to establish adult couple MNILs during the moratorium.

Second, the Secretary contends that, in enacting the DEFRA moratorium, Congress' sole intent was to override regulations issued in 1981. (Pet. at 18). He therefore argues that DEFRA is irrelevant, because this case turns upon 42 C.F.R. § 435.1007, which was promulgated in 1978. This argument ignores what Congress said it was doing: *In the Conference Committee report, Congress said that it intended to permit states to establish adult couple MNILs during the moratorium period.* Congress explicitly repudiated the Secretary's position that states could not do so because they would be establishing more than one income standard for families of the same size—a position which the Secretary adopted after 1981, and which rested upon the "single standard" language of TEFRA. (See pp. 4-5, *supra*).

Third, the Secretary argues that, because his predecessor did not rely upon TEFRA's single standard requirement in her final decision, he is not "exercis[ing] a power affected by the moratorium, [so that] the moratorium is totally irrelevant." (Pet. at 19). Again, the Secretary fails to discuss the Conference Committee report, which forbade the Secretary from "proceed[ing] with the imposition of any sanctions, or otherwise suggest[ing] to the States" that they may not use less restrictive standards than those required under a literal

reading of TEFRA. (App. 5-6). The Secretary would have this Court ignore the fact that Congress gave adult couple MNILs as an example of the "less restrictive" standards which the Secretary had forbidden, and which Congress intended to permit. The power which the Secretary seeks to exercise here—to forbid California from maintaining an adult couple MNIL, upon pain of fiscal sanctions[5]—is precisely the power which Congress intended to deny him when it enacted the moratorium.

Finally, the Secretary contends that the Ninth Circuit's decision would cost the federal government $50 million annually, and that the court's DEFRA holding therefore merits review. There is simply nothing in the record which supports the Secretary's assertion, nor is there any support for his cost estimate in reality. The California Department of Finance has estimated that the adult couple MNIL will increase the State's Medicaid expenditures by slightly less than $5 million annually, with half of that sum coming from state funds. Moreover, Congress contemplated this limited increase in Medicaid expenditures when it enacted the DEFRA moratorium.

Thus, the Secretary's contentions with respect to the Court of Appeals' DEFRA holding are without merit. That holding is consistent with the language and intent of the DEFRA moratorium. This case raises no important issues of law for this Court's review.

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[5] In the case of "an unapprovable change in the approved State plan," the Administrator of HCFA may withhold federal matching funds from the State. 45 C.F.R. § 201.6(a).

II. THE JUDGMENT RAISES NO IMPORTANT QUESTIONS OF LAW UNDER THE ADMINISTRATIVE PROCEDURE ACT

Because the DEFRA issue is completely dispositive of this case, this Court need not decide the questions raised in the Petition as to the validity of ROM 2572-D and the degree of deference which must be paid to that informally promulgated regulation—questions which DEFRA has robbed of any vitality. The broader issue of whether an informally promulgated regulation can ever be given "legislative effect" must await a case where it is presented "in the context of meaningful litigation." *The Monrosa v. Carbon Black Export, Inc.*, 359 U.S. 180, 184 (1959).

Respondents do wish, however, to address a few words to the Secretary's alarmist discussion of the Court of Appeals' holding regarding ROM 2572-D. In his Petition, the Secretary complains that, by giving the ROM provision legislative effect, the decision below "will wreak havoc on federal agencies and on the public . . . ." (Pet. at 16-17). This case does not warrant such overblown rhetoric.

The Ninth Circuit's decision arises from a unique set of circumstances unlikely to recur. Although it is now a year old, it has never been cited outside of the Ninth Circuit, and even that court appears to have limited the decision to its facts. Thus, the decision has not had any impact, much less the disastrous influence which the Secretary assigns to it. Moreover, there is plainly no conflict between the decision below and that of any other court of appeals. Finally, if certiorari were granted,

the Court could affirm the judgment on the basis of settled principles of administrative law. For these reasons, even absent DEFRA, the decision below raises no important questions for review.

A. Because of the Unique Features of This Case, The Court of Appeals' Opinion as to the Legislative Effect of ROM 2572-D Does Not Raise Important Issues of Law

The Secretary greatly exaggerates the import of the Court of Appeals' holding that ROM 2572-D is a legislative regulation.[6] The court recognized that "agency office manuals generally do not prescribe legislative rules with binding effect," (Pet. App. at 11a), but viewed this as an exceptional case for several reasons: The regulation is directed at states, rather than individuals; it provides guidance to states in establishing their MNILs; it was promulgated pursuant to a statute which delegates to the Secretary authority to prescribe standards to be used for that purpose; Congress had not required compliance with the Administrative Procedure Act's notice and comment provisions; and neither the State nor the public had complained of or was harmed by the lack of public participation. (Pet. App. 11a-16a) It is unlikely that this same combination of factors, each of which was a *sine qua non* of the decision, will recur.

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[6] No party ever urged that ROM 2572-D is a legislative regulation. Rather, all conceded that the provision is an interpretative guideline. The parties differed only as to its substantive validity. The Court of Appeals thus reached its conclusion without the benefit of briefing on the subject.

A recent Ninth Circuit case illustrates the limited reach of the decision below. In *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986), the court considered the validity of a provision of HHS' Carrier's Manual, an informally promulgated compilation of instructions prepared by the Secretary for private insurance carriers who act as intermediaries in the Medicare program. The provision at issue, which concerned Medicare coverage of ambulance service, resulted in denial of Medicare reimbursement to the plaintiffs. Although the *Linoz* court cited the decision below for the general distinction between "interpretative" and "substantive" rules, *id.* at 877, and held that the manual provision was "substantive", it did not hold that the provision had the force and effect of law. Rather, the court held that the provision was invalid because it had not been promulgated pursuant to the rulemaking provisions of the APA. *Id.* at 877-878.

The APA analysis used in this case was inapplicable in *Linoz*, as it will be inapplicable in virtually every case, because the critical factors present here were absent there: The Carrier's Manual provision which the *Linoz* plaintiffs challenged was not addressed to the states, and was not promulgated under an express grant of authority to make standards, *id.* at 877, n.10; moreover, the *Linoz* plaintiffs were harmed by the Secretary's failure to provide public notice and comment, and complained on that basis. Thus, *Linoz* indicates that even the Ninth Circuit will in future limit the decision below to its facts. There is no indication that the APA holding in this case will "wreak havoc

on federal agencies and on the public," as the Secretary claims. (Pet. at 16-17).[7]

B. The Judgment Can Be Explained on Alternative Grounds Which Do Not Raise Important Questions of Law

"[T]his Court reviews judgments, not opinions, . . ." *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). Although the court below gave ROM 2572-D "legislative effect", it could well have rested its judgment upon the ordinary deference which this Court and the courts of appeals have given similar regulatory material. Had it done so, the only question would have been whether the ROM provision is consistent with the statute and reasonably related to the purposes of Title XIX—a question which the court decided correctly. Because the result would have been the same even if the court's reasoning had been different, this case raises no important questions of law for this Court's review.

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[7] *Vance v. Hegstrom*, 793 F.2d 1018 (9th Cir. 1986), is the only case to date which followed the APA analysis used in the decision below. In *Vance*, the *Secretary* argued, and the court agreed, that it was required to give an HHS "directive" legislative effect. (HHS Reply Br. in No. 85-4050 at 6-7. *See also* HHS Opening Br. at 34-39 (arguing that the directive must be given "great weight and substantial deference if not 'legislative effect.'" (*Id.* at 39)). However, because the court invalidated the directive on the ground that it was inconsistent with Title XIX, plaintiffs did not seek review in this Court. Nor did the Secretary, although *Vance* raises the issue of the degree of deference owing to informally promulgated regulations far more squarely than does this case.

1. California Could Properly Rely on ROM 2572-D Although It was Not Promulgated in a Formal Rulemaking Proceeding

HHS administers both the Medicaid and the Medicare programs by means of a multitude of informally promulgated instructions and guidelines. The courts have uniformly held that these regulatory materials are entitled to deference, so long as they are consistent with the statute and the agency's regulations. *See, e.g., Charter Peachford Hospital, Inc. v. Bowen,* 803 F.2d 1541, 1546-47 (11th Cir. 1986); *Wisconsin Dept. of Health v. Bowen,* 797 F.2d 391, 397 (7th Cir. 1986), *pet. for cert. filed,* 55 U.S.L.W. 3337 (U.S. Nov. 11, 1986) (No. 86-648); *Sun Towers, Inc. v. Heckler,* 725 F.2d 315, 325 n.16 (5th Cir.), *cert. denied,* 469 U.S. 823 (1984). This Court has specifically sanctioned deference to such interpretations: "[R]ulings, interpretations and opinions . . . do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore v. Swift & Co.,* 323 U.S. 134, 140 (1944).

Indeed, in this case, the Secretary's own regulations specifically instruct states to look to HHS' informally promulgated regulatory materials in formulating their state plans. 45 C.F.R. § 201.3(d) provides: "Guidelines are furnished to assist in the interpretation of the regulations" which will be used in determining whether state plans may be approved. (App. 2). In the court below, the Secretary herself argued that ROM 2572-D was such an "interpretative guideline." (Pet. App. 10a).

Pointing to the foreword to the Regional Office Manual—a document which was never put in evidence—the

Secretary contends that the State should not have relied upon the ROM provision, although it was published in the CCH Medicare & Medicaid Guide, (1980 Transfer Binder ¶30,392 at 9521), along with a variety of other similar interpretations relating to standards for approval of state plans.[8] The Secretary's contention that the ROM was for internal use only, when examined in light of the content of ROM 2572-D and of the Manual's other published guidelines, is truly remarkable. The published interpretations cover a wide variety of subjects of vital interest to the states: Issues regarding state organization and administration of Medicaid plans, (1979-2 Transfer Binder ¶30,124); federal reimbursement for staffing and training costs, (*id.*, ¶30,125); and permissible limitations on the scope of coverage of various services, (*id.*, ¶29,997), to name but a few. The thrust of the Secretary's argument is that HHS can review state plans and decide whether to approve them on the basis of "secret law" which has not been and may not be disclosed to the states. If the Ninth Circuit had so held, that, indeed, would be a ruling which would merit this Court's review. In contrast, the Ninth Circuit's holding that California could rely upon the ROM does not raise an important issue of law.[9]

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[8] The table of contents to the 1980 Transfer Binder lists 21 ROM sections published therein, some with several subparts. Each is introduced by the sentence, "HCFA has issued guidelines reproduced below . . . ." Similarly, the 1979-2 Transfer Binder contains 35 sections of the ROM.

[9] The Petition asserts that ROM 2572-D was eliminated from a 1980 revision of the ROM. (Pet. at 17). Certainly, Congress was not made aware of this revision in 1983-84, when it con-

(Continued on following page)

2. ROM 2572-D is Consistent with § 1903(f) and With HHS' Regulations

The Secretary insists that ROM 2572-D is invalid because it is inconsistent with § 1903(f) and with 42 C.F.R. § 435.1007. He ignores the fact that the guideline fills a gap in both the statute and the regulation, and is consistent with both.

Section 1903(f)(1)(B)(i), 42 U.S.C. § 1396b(f)(1)(B)(i), provides: "[T]he applicable income limitation with respect to any family is the amount determined, *in accordance with standards prescribed by the Secretary*, to be *equivalent* to 133⅓ percent of the highest amount which would *ordinarily* be paid to a family *of the same size*" under the AFDC program. (Pet. App. 46a). As the Court of Appeals noted, this provision does not contemplate "a mathematical procedure", but allows latitude for the Secretary to develop standards for "equivalent" MNILs. (Pet. App. 7a).[10]

(Continued from previous page)

sidered the validity of ROM 2572-D. Nor is there any evidence of the revision in the record—indeed, the Secretary raised this contention for the first time in his petition for rehearing, and then only in a footnote. (Reh. Pet. at 9 n.3). And as he noted there, HCFA's April, 1983 letter to the Regional Administrator stated that the ROM provision had *not* been repealed. (App. 13-14). That letter correctly recognized that, in order to repeal a "statement of general policy or interpretation of general applicability" such as ROM 2572-D, the agency was required, at a minimum, to publish a notice in the Federal Register. 5 U.S.C. § 552(a)(1)(D). *See Cabias v. Egger*, 690 F.2d 234, 238 n.8 (D.C. Cir. 1982). No such notice has ever been published.

[10] The Secretary contends that he only has limited authority to promulgate standards "establishing the State's determination as to which of its AFDC payment levels for a family of a given

(Continued on following page)

As HCFA recognized in ROM 2572-D, the statute—and HHS' implementing regulation, which contains the identical language—create an ambiguity with respect to adult couples, because states do not *ordinarily* pay AFDC grants to families of two adults. *See* 42 U.S.C. § 606(b) (AFDC defined as "money payments with respect to a dependent child or dependent children"). A state's AFDC payment level for a family of two is thus based upon the needs of one adult and one child. The ROM properly permitted the states "to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child" by setting adult couple MNILs. (App. 9). Certainly, this interpretation was well within the Secretary's discretion, and was consistent with the purposes of Title XIX.

Congress approved the Secretary's interpretation when it enacted the DEFRA moratorium. The House explicitly found, and the Conference Committee implicitly assumed that the policy set out in ROM 2572-D was "sound". See pp. 5-8, *supra*. The Conference Committee differed with the House only in its solution to the problem created by TEFRA: The House would have permanently "relax[ed] the single standard requirement only in the limited

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(Continued from previous page)

size is the 'highest' that would 'ordinarily be paid' to a family of that size.". (Pet. at 12). There is absolutely no support for this narrow reading in the statute or in its legislative history. Indeed, this Court has recognized that when Congress used language of delegation such as that in § 1903(f), it "conferred on the Secretary exceptionally broad authority to prescribe standards" implementing the Act. *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

circumstance'' in which a state adopts an adult couple MNIL (App. 20); the Conference Committee refused permanently to ''relax the single standard requirement'' in this limited respect, but rather proposed a temporary moratorium, during which states are free to adopt a variety of ''less restrictive'' standards and methodologies, including adult couple MNILs. Where, as here, Congress '' 'has ratified [an administrative construction] with positive legislation,' we cannot but deem that construction virtually conclusive.'' *Commodity Futures Trading Comm'n. v. Schor,* 478 U.S. —, 92 L.Ed.2d 675, 690, 106 S.Ct. 3245 (1986).

3. The Decision as to the Validity of ROM 2572-D Raises No Important Issue of Law

Even if this Court were persuaded that ROM 2572-D is inconsistent with § 1903(f) of the Act—a conclusion which Congress precluded in DEFRA—that in itself would not warrant review. No other state has adopted an adult couple MNIL as of this date, and no decision of either a state or federal appellate court is in conflict with that of the court below. Nor is it likely that states will rush to establish such income standards if this Court denies review: Just as California must pay 50% of the increased cost resulting from adoption of its adult couple MNIL, so any state which follows its example must pay part of the cost itself.[11]

---

[11] The federal government pays a percentage of each state's Medicaid expenditures, on the basis of the formula set out in 42 U.S.C. § 1301(a)(8). The current percentages, which vary by state, are published at 4 CCH Medicare & Medicaid Guide ¶ 35,908.

Nor is the Court of Appeals' judgment in conflict with any opinion of this Court. Certainly, the judgment does not conflict with this Court's decision in *Schweiker v. Hansen*, 450 U.S. 785 (1981). There, the plaintiff relied upon the doctrine of equitable estoppel because the relief which she sought was contrary both to the clear mandate of the Social Security Act and of HHS' regulations. But a claim based upon an agency's regulations, whether "legislative" or "interpretative", does not raise an issue of estoppel. *See Lyng v. Payne*, 476 U.S. —, 90 L.Ed.2d 921, 931-32, 106 S.Ct. 2333 (1986). *Hansen*, of course, did not preclude the court below from finding that ROM 2572-D is consistent with § 1903(f) and is entitled to deference.

The Secretary's real quarrel here lies not with the Court of Appeals, but with Congress. He complains that the judgment "limits [his] ability to enforce the statutory cap on federal financial participation in Medicaid." (Pet. at 19). But, although DEFRA, in its broad outlines, may have been "a deficit reduction measure", (*id.*), in the moratorium provision, Congress expressly permitted the states to adopt "less restrictive" standards and methodologies, including adult couple MNILs, so long as they are "reasonable", notwithstanding the fiscal implications. The Secretary should address his comments to Congress, rather than to this Court. There is no reason for this Court to grant review.

———o———

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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Attorney General of the
State of California
RALPH JOHNSON*
Deputy Attorney General
Attorneys for Respondent Kizer

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* Counsel of Record

January, 1987

APPENDIX A

Section 2373(c) of the Deficit Reduction Act of 1984, Pub.L. 98-369, 98 Stat. 1112, provides:

> (1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined to be in violation of section 1902(a)(10)(C)(i)(III) of such Act on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.
>
> (2) The moratorium period is the period beginning on the date of the enactment of this Act and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).
>
> (3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.
>
> (4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.

* * * *

45 CFR § 201.3(d) provides:

> Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet, the requirements for approval are based on relevant Federal statutes and regulations. Guidelines are furnished to assist in the interpretation of the regulations.
>
> * * * *

APPENDIX B

The report of the DEFRA Conference Committee, H.R. Rep. 98-861, 98th Cong., 2d Sess. (1984), provides with respect to § 2373(c) of DEFRA:

Present law

Titles V and XIX of the Social Security Act contain certain technical errors.

House bill

Makes technical corrections to titles V and XIX of the Social Security Act.

Senate bill

No provision.

Conference agreement

The conference agreement follows the House bill with a modification as follows. The conference agreement directs the Secretary not to take any compliance, disallowance, penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, is using an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology. The Secretary is further directed to report to Congress within 12 months of enactment on the impact of the application of income and resource standards and methodologies under the cash assistance programs to medically needy recipients and other noncash eligibles. The moratorium on Secretarial action is to run from the date of enactment until 18 months after the date on which the Secretary submits her report.

In the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35 (OBRA), States were given certain flexibility in structuring their medically needy programs. They were allowed to limit coverage to cer-

tain categories of medically needy individuals, and to vary the services they offered to the different groups they covered. No change was made or intended with regard to financial eligibility policy. Before OBRA, States could establish income or resource standards or methodologies for their medically needy programs that were, in some cases, less restrictive than those used in the related cash assistance programs.

Effective October 1, 1981, the Secretary issued interim regulations to implement these changes. These regulations made major changes in the pre-OBRA financial eligibility rules, allowing the States to impose more restrictive standards and methodologies than under previous law.

Section 137[(b)](8) of the Tax Equity and Fiscal Responsibility Act, P.L. 97-248 (TEFRA), amended the Medicaid statute to clarify that Congress did not intend to change the policies governing the income and resource standards and methodologies for determining eligibility of the medically needy from those in effect before OBRA. This amendment provided in part that the methodology to be used in determining income and resource eligibility for the medically needy must be the "same methodology" used under the revelant cash assistance program.

The Department has not revised the 1981 interim regulations or otherwise published regulations to implement the TEFRA amendment. However, it is the understanding of the conferees that the Department has implemented this provision in an overly literal fashion, without taking into account the intent of the TEFRA clarification.

For example, the Department is treating certain income and resource rules as "methodology" that must strictly follow SSI or AFDC rules, even though all States with medically needy programs have traditionally been permitted to use less restrictive rules

in certain areas. Thus, the Department has taken the position that aged, blind, and disabled medically needy applicants who enter nursing homes and who have marginally excess resources on the first day of the month can not attain Medicaid eligibility during the month, even after their resources are sufficiently depleted by medical costs, because SSI rules only allow eligibility from the first of the month. The Department has also indicated that it may impose quality control sanctions against the States that are using eligibility procedures that were allowed before OBRA and which make sense in the context of the medically needy program but which happen to be less restrictive than the relevant cash assistance procedures. Similarly, the Department has taken the position that the "single standard" requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same family size depending on the relative numbers of adults and children.

The Department's overly restrictive interpretation of section 137[(b)](8) of TEFRA has posed grave administrative problems for the States and threatens to cause great hardship for applicants and beneficiaries. It is also clear to the conferees that the strict application of the cash assistance rules to the medically needy and other noncash groups produces unintended, and in some cases, undesirable, consequences. The conferees have therefore decided to impose a moratorium on the Department's implementation of the TEFRA amendment until the Congress has an opportunity to study and legislate on the matter.

It is the understanding of the conferees that the Department has not yet actually taken a disallowance or quality control penalty against any State. The conferees intend that, during the moratorium, the Secretary not proceed with the imposition of any sanctions,

or otherwise suggest to the States that they must use more restrictive cash assistance standards and methodologies in their medically needy or other noncash recipient programs. States may use less restrictive standards and methodologies in their noncash programs, although they are still foreclosed from being more restrictive than the relevant cash assistance programs. It is the expectation of the conferees that the States will be reasonable in establishing less restrictive variations in the cash assistance methodologies and standards.

APPENDIX C

ROM 2572-D provides:

STATEMENT OF REPLY:

This is in response to a verbal request . . . for clarification of policy regarding the establishment of medically needy income levels. Specifically, the request addressed the issue of setting a medically needy income level for two adults based upon the AFDC payment to a two-person family composed of one adult and one child.

CITATION OF LAW:

Section 1903(f) of the Social Security Act.

REGULATION(S): 42 CFR 435.1007.

REFERENCE TO OTHER RESOURCES:

PIQ 76-15 (MSA); NCSS D-2, July, 1976; Office of Research and Statistics, SSA.

DISCUSSION: This issue involves concerns similar to those inherent in the determination of a medically needy income level for a family of one. PIQ 76-15 (MSA) dated January 22, 1976, addresses this subject and recognizes the existence of the differing maintenance needs of dependent children and medically needy adults. It reads:

> "Per Section 1903(f)(3) of the Social Security Act and 45 CFR 248.4 (b)(4)(ii)(A) in applying the 133⅓ percent limitation to the medically

> needy income levels for single individuals, the 'highest amount which could ordinarily be paid' under the State AFDC program is an amount reasonably related to the State AFDC payment amount for two-person families. Where there is no amount of payment for one person in the AFDC program which is reasonably related to the AFDC payment for two-person families, for example, because the AFDC plan does not provide for payments to single individuals, or such payments are based on reduced need standards applicable only to dependent children and are therefore not related to reasonable maintenance needs of medically needy adults, an amount for one-person families must be established by the State to meet the requirements of this provision."

Additional documentation of the differing maintenance needs of dependent children and adults is offered in the statistics of Federal and State cash payments to these persons:

(1) A comparison of the States' 1976 basic need standards for an AFDC family of two (one adult and one child) and an AFDC family of three (one adult and two children) reveals an average monthly difference of 54.09. Thus, the presence of one additional child in an

AFDC family is recognized as incurring an additional $54.09 to that family's basic needs.

(2) A survey of the 1976 payment levels of twenty-two States offering optional State supplementation for "Basic Needs" to aged persons living independently reveals an average monthly difference of $109.19 between the payment allotted an individual and the payment allotted a couple. Thus, the presence of one additional aged adult in a family is recognized as raising the family's maintenance needs by $109.18.

(3) The Supplemental Security Income financial eligibility standards effective July 1, 1977, authorize a payment of $177.80 to a single person and $266.70 to an eligible couple. Thus, the presence of one additional aged adult is recognized as contributing $88.90 to the couple's maintenance needs.

In order to effectively acknowledge the greater maintenance needs of an adult as opposed to those of a child, the States may set a separate medically needy income level for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. For example, Montana has established a medically needy income level for two adults at $287 which is within the aforementioned limits of $167 and $334 respectively. This level conforms to the above criteria, satisfies the regulatory requirement of "reasonable relatedness," and recognizes the differing maintenance needs of an adult and a child. The medically needy income level for one adult and one child may not, of course, exceed 133⅓ percent of the AFDC cash payment for a family of two persons.

In view of the greater maintenance needs of an adult as opposed to a child, the regulatory mandate of "rea-

sonably related" income levels contained in [42 CFR 435.1007], and in the interest of comparable treatment of persons with similar needs, the States should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults.

June 19, 1979

HCFA-ROM-31

APPENDIX D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
Health Care Financing Administration
Memorandum

Date Mar. 16, 1983

From Associate Regional Administrator
Program Operations

Subject Medically Needy Income Levels for Single Adults and Couples

To Elmer Smith, Director
Office of Eligibility Policy, BERC
Baltimore, Maryland 21207
DPO-222

Refer to

The State of California is under considerable pressure from recipient groups to raise the medically needy income levels for one or two adult person families to higher levels than those for a family consisting of a parent and child. State Assembly Bill #799 revoked California's Special Income Deduction which had previously reduced the spenddown amounts for aged, blind, and disabled medically needy recipients. The HCFA Administrator had disapproved the Special Income Deduction as contrary to federal regulations at 42 CFR 435.1007 which fixes the upper limit on MNIL(s) at 133⅓% of the AFDC payment level for a family of the same size.

Section 2572 of the Regional Office Medicaid Manual (R.O.M. #31 of June 19, 1979 - attached) allowed States to recognize the greater maintenance needs of a single adult and a couple as opposed to a parent and child in setting medically needy income levels. For a MNIL for a family of two adults States could use an amount between 133⅓% of the AFDC payment level for one and for three to recognize the higher mainten-

ance needs of a couple as opposed to a mother and child.

This policy was based on a previous interpretation of the words "reasonably related" stated in federal regulations at 42 CFR 435.1007 and was originally issued in PIQ-77-77 (MSA), June 27, 1977. For a medically needy income level to be considered "reasonably related" to the AFDC payment level for a family of the same size, it was interpreted that the higher needs of adults than children in one and two person families should be accommodated.

T.E.F.R.A., however, has mandated that States use one medically needy income level for all medically needy groups based on family size. Therefore, if a State is to have a different MNIL for a MN adult than it has for a MN child, this practice would constitute the use of different MNIL(s) for different groups of MN recipients and seemingly violate T.E.F.R.A. Furthermore, it appears that the same problem pertains to a State using a lower MNIL for a mother and a child than for an aged, blind, or disabled couple.

Thus, we are asking whether Section 137B of T.E.F.R.A. has invalidated R.O.M. #31 of 6/19/79. If the concept of separate levels for adults and children is still applicable, please advise us whether this practice is optional or mandatory and additionally pertains to families of all sizes dependent upon whether the family group contains one or two adults.

We would appreciate your earliest possible reply on this issue as the State is drafting legislation to raise the medically needy income levels in accordance with R.O.M. #31. We are trying, consequently, to avoid potential compliance problems in this regard. If you have any questions, please call Bruce Campbell of my staff at 556-2191.

/s/ John L. O'Hara, Jr.

Attachment

APPENDIX E

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FQA—63 April 15, 1983

Director
Bureau of Eligibility, Reimbursement
and Coverage

Medically Needy Income Levels for Single Adults and Couples (Your Memorandum Dated March 16, 1983)—
POLICY INFORMATION FOR ALL REGIONS

Regional Administrator
Region IX, San Francisco
Attn: Policy and Technical Assistance Branch
Division of Program Operations

You asked whether, for a specified family size, States may employ more than one medically needy income level (MNIL). That is, may the MNIL vary by family composition depending on the relative numbers of adults and children (as indicated in Regional Office Manual (ROM) section 2572)?

Section 1902 (a)(10)(C) of the Social Security Act (as recently amended by section 137 (b)(8) of TEFRA) provides for a "single standard to be employed in determining income and resource eligibility for all such groups" (of medically needy individuals). Establishing different medically needy levels that would vary by family composition would in effect, result in application of more than a single standard for a group. Thus, we do not believe that States may apply different medically needy income levels for families of the same size but differing in composition of adults and children. We are currently in the process of

clearing regulations which reflect this interpretation through HCFA and the Office of the General Counsel for eventual publication in the *Federal Register*. Upon final clearance, we will take steps to invalidate ROM section 2572.

If you have any questions regarding this memorandum, please call Richard Strauss on (FTS) 934-0629.

/s/ Elmer Smith for
Larry A. Oday

FQA—63 RStrauss:kh 03/30/83
Revised: FQA—63 DCoyne:kh 04/06/83
Revised: MSvolos:mmh 04-11-83
Disc-Kathy II, MEDICALLY NEEDY INC

APPENDIX F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to:

DPO-222

Region IX
Office of the
Regional Administrator
100 Van Ness Avenue
San Francisco, CA 94102

Mrs. Doris Soderberg, Acting Deputy Director
Health Care Policy and Standards Division
Department of Health Services
714 P Street
Sacramento, California 95814

Dear Mrs. Soderberg:

You inquired whether States may employ more than one medically needy income level varying by family composition based on the relative numbers of adults and children in an applicant's family.

Our research has confirmed that Section 1902(a)(10)(c) of the Social Security Act (as recently amended by section 137(b)(8) of TEFRA) provides for a single standard to be employed in determining income and resource eligibility for all such groups of medically needy individuals. Establishing different medically needy income levels that would vary by family composition would, in effect, result in application of more than a single standard for a MN group.

Thus, we do not believe that States may apply different medically needy income levels for families of the same size but differing in the composition of adults and children. HCFA is in the process of finalizing regulations which reflect this interpretation for eventual publication in the *Federal Register*.

The statutory change in TEFRA is considered to be self-implementing and, to the extent that current regulations conflict with the newly revised statute, they no longer have any force and effect.

If you have further questions on this matter, please contact Bruce Campbell of my staff at (415) 556-2191.

Sincerely,

/s/ John L. O'Hara, Jr.
Associate Regional Administrator
Program Operations

cc: Caroline Cabais, Eligibility Branch Chief

APPENDIX G

Section 361 of H.R. 5394, 98th Cong., 2d Sess. (1984), provided:

(a) Section 1903(f)(3) of the Social Security Act (42 U.S.C. 1396b(f)(3)) is amended—

(1) by inserting "(A)" after "(3)", and

(2) by adding at the end the following new sub-paragraph:

"(B) For purposes of paragraph (1)(B), in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the 'highest amount which would ordinarily be paid to a family of the same size' under the State's plan approved under part A of title IV of this Act shall, at the State's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. In the case of a State which has an applicable income limitation under this subsection which is equal to the maximum applicable income limitation permitted consistent with paragraph (1)(B) for families other than those described in the previous sentence, section 1902 (a)(10)(C)(i)(III) shall not prevent the State from establishing under the previous sentence an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families".

(b) The amendment made by subsection (a)(2) shall apply to payments to States under section 1903 of the Social Security Act for calendar quarters beginning on or after October 1, 1984.

APPENDIX H

H.R. Rep. 98-442, Pt. 1, 98th Cong., 1st Sess. (1983), provided with respect to § 211 of H.R. 4136, (subsequently § 361 of H.R. 5394):

> Under current law, States have the option of extending Medicaid coverage to the "medically needy." These are low-income adults with dependent children, or aged, blind, or disabled individuals, who have the characteristics necessary to qualify for cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs, but whose income or resources are too high to permit them to do. In order to receive Medicaid coverage under a State's medically needy program, an individual must "spend down" until his or her medical expenses, when applied against income for the relevant accounting period, reduce that income below the State-established medically needy income level.
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> The medically needy income level may not be set at a level higher than an amount equal to 133⅓ percent of the highest amount that would ordinarily be paid to an AFDC family of the same size without any income or resources. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, Federal guidelines allowed States to set the medically needy income levels for two adults at an amount equal to 133⅓ percent of the AFDC payment for a family of one adult and two children. (HCFA-ROM-31, June 19, 1979). This guideline recognized that a State could find that an adult had greater maintenance needs than a child, and could set its medically needy income level for two adults accordingly.
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> It is the understanding of the Committee that the Department of Health and Human Services has reversed its policy on this point and taken the position that a medically needy income level for two adults could not, consistent with Federal law, be set at an amount equal to 133⅓ percent of the amount ordinar-

ily paid to an AFDC family of three without income or resources. The Department's new policy appears to be that the medically needy income level for two adults may not be set higher than an amount equal to 133⅓ percent of the amount ordinarily paid to an AFDC family of two without income or resources.

The Committee bill would reinstate the Department's previous policy. States could, at their option, set the medically needy income level for two adults, one of whom is aged, blind, or disabled, at an amount no higher than 133⅓ percent of the highest amount that would ordinarily be paid to a family of one adult and two children without any income or resources under the State's AFDC plan.

The Committee is at a loss to understand why the Department has decided to alter its policy in this regard. The policy is sound; a State could quite logically determine that the maintenance needs of adults differ from those of dependent children. The Committee recognizes that the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, gave the States more flexibility with respect to the operation of their medically needy programs. The OBRA changes did not, however, extend to income and resource eligibility requirements for the medically needy. This was reaffirmed in the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, which attempted to reinstate the medically needy income and resource eligibility policies that had been in effect prior to the enactment of OBRA and that the Department had improperly attempted to alter by regulation. The TEFRA provisions, among other things, specified that States are to employ a single standard in determining income and resource eligibility for all groups that the State chooses to cover. The Committee bill makes clear that this single standard requirement does not justify a rejection of the valid 1979 policy with respect to two medically needy adults.

To avoid any further confusion on this point, the Committee provides the folowing hypothetical example of how its amendment would work. Assume that the highest AFDC cash payment is $300 per month in the case of a family of two with no income or resources and $400 per month in the case of a family of three with no income or resources. The State could set its medically needy income level for two adults, one of whom was aged, blind, or disabled, at a level no higher than 133⅓ percent of $400, or $533.32 per month. The State could, of course, set its medically needy income level for two adults at a lower level, say, 133⅓ percent of the $300 payment to an AFDC family of two, or $400 per month. If the State set its medically needy income level for two adults at $400, the income level for AFDC-related medically needy families would have to be the same. If the State chose to set its medically needy income level for two adults above $400 (subject to the $532 per month ceiling), the medically needy income level for a two-person AFDC-related family would have to be set at $400. Medically needy income levels for three-person AFDC-related families would be determined as under previous law. In short, the Committee amendment would relax the single standard requirement only in the limited circumstance in which a State sets its medically needy income level for two adults in excess of 133⅓ percent of the highest cash payment ordinarily made to a family of two under the State's AFDC program.